

**F: POST-OP FOLLOW-UP**

(for any moderate or severe AE, inform appropriate supervisor and

F1: Date          
d d m m y y y yF2: Type of visit ☐ 48hr ☐ 3/4 day ☐ 7 day ☐ Other specify \_\_\_\_\_F3: Post-op Adverse Event? ☐ No ☐ Yes

If Yes, refer to AE description form and complete the following

F4: Type of AE \_\_\_\_\_ F5: If Yes, how would you rate it? ☐ Mild ☐ Moderate ☐ Severe

F6: Notes: \_\_\_\_\_

F7: Name of reviewing officer \_\_\_\_\_ Signature \_\_\_\_\_

F8: Date          
d d m m y y y yF9: Type of visit ☐ 48hr ☐ 3/4 day ☐ 7 day ☐ Other specify \_\_\_\_\_F10: Post-op Adverse Event? ☐ No ☐ Yes

If Yes, refer to AE description form and complete the following

F11: Type of AE \_\_\_\_\_

F12: If Yes, how would you rate it? ☐ Mild ☐ Moderate ☐ Severe

F13: Notes: \_\_\_\_\_

F14: Name of reviewing officer \_\_\_\_\_ Signature \_\_\_\_\_

**G: CLINICAL NOTES**


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Version 2 June 19, 2012

Ministry of Health

**Infant Male Circumcision Client Form**Client Number:      -   Date        
d d m m y y y yTheatre Register Number: (As per facility procedures)      **FACILITY/SITE DETAILS**

Facility/Site Name \_\_\_\_\_

Service Delivery Type: Home ☐ Facility ☐ Other ☐ \_\_\_\_\_

Village/Estate \_\_\_\_\_ Sub Location \_\_\_\_\_

District \_\_\_\_\_ County \_\_\_\_\_

**A: CLIENT/PARENT INFORMATION**A1: Infant Name \_\_\_\_\_ A2: DOB        
d d m m y y y yA3: Mother's Name \_\_\_\_\_  
First Name Middle Name Last Name

A4: Age \_\_\_\_\_ A5: Telephone Contact \_\_\_\_\_

A6: Father's Name \_\_\_\_\_  
First Name Middle Name Last Name

A7: Age \_\_\_\_\_ A8: Telephone Contact \_\_\_\_\_

A9: Residence (infant): Village/Estate \_\_\_\_\_ Sub Location \_\_\_\_\_  
District \_\_\_\_\_ County \_\_\_\_\_

A10: Main source of VMMC information

☐ Radio/TV ☐ Print Media ☐ Road show ☐ Mobilizer/CHW ☐ Maternity/MCH☐ Other (specify) \_\_\_\_\_

## B: MEDICAL HISTORY AND PHYSICAL EXAMINATION

(Note: Check one box for each item)

B1: Family history of bleeding disorder ☐ Yes ☐ No

B2: Client presenting with

(1) Fever ☐ Yes ☐ No (2) Jaundice ☐ Yes ☐ No

(3) Undescended testis(es) ☐ Yes ☐ No (4) Scrotal Swelling ☐ Yes ☐ No

(5) Abnormal penile appearance ☐ Yes ☐ No

(6) Congenital Anomaly, (specify) \_\_\_\_\_

(7) Other, (specify) \_\_\_\_\_

B3: Pregnancy/Delivery

(1) Site of delivery ☐ Home ☐ Facility ☐ Other (2) Mode of delivery ☐ C-section ☐ Vag

(3) Pregnancy complications, (specify) \_\_\_\_\_

B4: Any known allergies? ☐ Yes ☐ No If Yes, specify \_\_\_\_\_

B5: Weight: \_\_\_\_\_ kg

## C: ELIGIBILITY FOR CIRCUMCISION

C1: Client eligible for circumcision?

C1.1: In good health ☐ Yes ☐ No

C1.2: Parents counseled ☐ Yes ☐ No

C1.3: Parent/guardian consent obtained ☐ Yes ☐ No

If No **for any of the above, explain** \_\_\_\_\_

**NOTE: PROCEED WITH CIRCUMCISION ONLY IF ALL BOXES HAVE BEEN CHECKED "YES"**

## D: CIRCUMCISION PROCEDURE

D1: Date of circumcision 

d	d

m	m

y	y	y	y

D2: Start Time [24 hour clock]: |\_\_\_\_\_| |\_\_\_\_\_| : |\_\_\_\_\_| |\_\_\_\_\_|

D3: End Time |\_\_\_\_\_| |\_\_\_\_\_| : |\_\_\_\_\_| |\_\_\_\_\_|

D4: List pre operative medication given (if any) \_\_\_\_\_

D5: Anaesthesia used:

D5.1: Type

☐ Lignocaine

☐ Other (specify \_\_\_\_\_)

D5.2: Concentration

☐ 1% ☐ 2%

D5.3: Volume (mls)

D6: Type of circumcision procedure ☐ Mogen ☐ Other, (specify): \_\_\_\_\_

D7: Adverse Events during operation? ☐ Yes ☐ No

D8: Type of AE \_\_\_\_\_ (refer to AE description form)

D9: If Yes, how would you rate it? (refer to AE description form) ☐ Mild ☐ Moderate ☐ Severe

D10: Name of clinician \_\_\_\_\_

D11: Cadre: ☐ MO ☐ CO ☐ Nurse \_\_\_\_\_  
Signature

D12: Name of Assistant \_\_\_\_\_

D13: Cadre: ☐ MO ☐ CO ☐ Nurse \_\_\_\_\_  
Signature

## E: IMMEDIATE POST-OP

E2: Medication given: ☐ Pannadol ☐ Other \_\_\_\_\_ ☐ None

E3: Parent/guardian given post-op instructions? ☐ Yes ☐ No

**NOTE: IF A MODERATE OR SEVERE AE IS OBSERVED, INFORM APPROPRIATE SUPERVISER AND COMPLETE INCIDENT FORM IMMEDIATELY**